

## The Department of Vermont Health Access Medical Policy

**Subject: Prosthetics and Orthotics**

**Last Review: January 2, 2015**

**Revision 3:**

**Revision 2:**

**Revision 1:** January 10, 2014

**Original Effective:** June 10, 2013

### Description of Service or Procedure

Per Medicaid Rule 7508, “a prosthetic device is a replacement, corrective or supportive device to: 1) artificially replace a missing portion of the body; 2) prevent or correct physical deformity or malfunction; or 3) support a weak or deformed portion of the body. Prosthetics include orthotics.”

**Prefabricated** devices are manufactured in a quantity without a specific patient in mind. They may be modified for use by a specific beneficiary (“custom fitted”). *A device assembled from prefabricated parts is considered prefabricated.* (LCA A19806, 2012).

**Custom devices** are manufactured to fit a specific patient and require a prescription. It is fabricated from basic materials and involves *substantial work* to customize it to the specific patient. It may include some prefabricated components. (LCA A19806, 2012).

### Disclaimer

Coverage is limited to that outlined in Medicaid Rule that pertains to the beneficiary’s aid category. Prior Authorization (PA) is only valid if the beneficiary is eligible for the applicable item or service on the date of service.

### Medicaid Rule

[7102.2](#) Prior Authorization Determination

[7103](#) Medical Necessity

[7508](#) Prosthetic Devices

Medicaid Rules can be found at <http://humanservices.vermont.gov/on-line-rules>



## **Coverage Position**

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Prosthetics/orthotics may be covered for beneficiaries:

- When the device is prescribed by a licensed medical provider, enrolled in the Vermont Medicaid program, operating within their scope of practice in accordance with Vermont State Practice Act and, who is knowledgeable in the use of prosthetics/orthotics, and who provides medical care to the beneficiary AND
- When the clinical guidelines below are met.

## **Coverage Guidelines**

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The prosthetic/orthotic may be covered for beneficiaries when the following criteria are met:

- The beneficiary has a medical condition that results in the need for a prosthetic/orthotic to: 1) artificially replace a missing portion of the body; 2) prevent or correct physical deformity or malfunction; or 3) support a weak or deformed portion of the body. **AND**
- **For custom devices only:** Where the device is properly evaluated by a qualified professional practitioner with specialized skills in the evaluation of prosthetics/orthotics. Depending on the nature of the device, this practitioner may be a physical or occupational therapist, or a physician/physician assistant/nurse practitioner. Fitting of the device must be performed by one of the above listed professionals or by a supplying provider who has been certified to ensure that the prescription is properly fulfilled.

## **Clinical guidelines for repeat service or procedure**

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Medicaid expects that beneficiaries will care for their prosthetics/orthotics properly so that they will be usable for at least the duration recommended by the manufacturer. Most prefabricated devices have a reasonable useful lifetime of at least 1-3 years. Custom devices are expected to have a reasonable useful lifetime of at least 3 years. Prior authorization is required should an excess quantity be required.

Coverage for replacement equipment will be provided only when the existing device or system no longer effectively addresses the beneficiary's needs. A police report is required for items that are lost, stolen, or irreparably damaged in an accident. Devices will be covered for repair if the repair price is less than 50% of the replacement price.

Per Medicaid Rule 7508.3:

- Coverage of Medicaid-approved shoes is limited to two pairs per adult beneficiary per calendar year unless a prior authorization review finds special circumstances that warrant additional pairs.

## **Type of service or procedure covered**

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Per Medicaid Rule 7508.2, "items and services that have been pre-approved for coverage are limited to:

- Artificial limbs;
- Artificial larynx;
- Breast forms [limited to post-mastectomy];
- Prosthetic shoes;
- Ostomy products;
- Parenteral and enteral nutrition services;
- Prosthetic eyes;

- Braces and trusses for the purpose of supporting a weak or malformed body member;
- Orthotic shoes as an integral part of a leg brace or affixed to an integral part of a leg brace;
- Aircast splints;
- Shoe lifts, elevation heels, wedges; and
- Molded orthopedic shoes when prescribed for diabetes, severe rheumatoid arthritis, ischemic, intractable ulceration, congenital defects, and deformities due to injuries.

The complete policy regarding hearing, visual, vocal, and dental prostheses is contained in rules 7315, 7316, 7507 and 7312.4.”

**Custom items are covered only when prefabricated devices cannot meet the medical need.** Medicaid rule 7102.2 requires that the least expensive, medically appropriate item be supplied. Therefore, in situations where a prefabricated device is available, the ordering and dispensing of a custom device requires physician documentation that demonstrates the medical need for a custom device.

Regardless of whether prior authorization is required or not, a provider medical necessity form must be completed, current for the billed date of service and available in the beneficiary’s chart for legal and auditing purposes.

Per Medicaid Rule 7508.3:

- Prosthetic devices must be prescribed by a physician or podiatrist who is enrolled with Vermont Medicaid.
- Devices must be appropriate for the beneficiary’s age, gross and fine motor skills, developmental status, mental functioning, and physical condition.
- Payment will be made for **one** primary piece of medical equipment.
- Custom made arch supports prescribed by a physician or podiatrist are covered when they meet the definition of an orthotic.

Per Medicaid Rule 7603.3:

- For individuals not covered by Medicare residing in a nursing facility, Medicaid covers prosthetic devices and leg, arm, back and neck braces.

#### **Type of service or procedure not covered (this list may not be all inclusive)**

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Per Medicaid Rule 7508.3:

- Duplicate items are not covered (e.g., two pairs of customized orthotics)
- Duplicate services/equipment in multiple locations will not be covered.

Per Medicaid Rule 7508.5:

- Orthopedic shoes when prescribed for flat feet are not covered;
- Orthotics/prosthetics that primarily serve to address social, recreational, or other factors and do not directly address a medical need are not covered.

Per Medicaid Rule 7508.7:

- Prosthetic/orthotic suppliers may not bill Medicaid for items furnished by hospitals to their inpatient or outpatients. Hospitals cannot bill separately for prosthetic or orthotic supplies.
- Modifications made within 60 days of purchase are not covered because they are considered part of the initial reimbursement.

Certain accessories/components cannot be covered in addition to the base code, because:

- They are considered part of the base device;
- They are considered not reasonable and necessary;
- They are incompatible with the base code.

Examples of this include, but are not limited to, the following table related to knee orthotics (Local Coverage Article A46762, 2014):

Base Code- prefabricated devices:	Additional codes: not separately payable due to: considered part of the base code, not reasonable and necessary, or incompatible with the base code.
K0901	K0672, L2275, L2390, L2425, L2430, L2750, L2780, L2810, L2820, L2830, L4002
K0902	K0672, L2275, L2390, L2425, L2430, L2750, L2780, L2810, L2820, L2830, L4002
L1810	L2390, , L2750, L2780, L4002
L1812	L2390, L2750, L27780, L4002
L1820	L2390, , L2750, L2780, L2810, L4002
L1830	K0672, , L4002
L1831	K0672, L2390, , L2425, L4230, L2750, L2780, , L2810, L2820, L2830, L4002
L1832	K0672, L2390, , L2425, L4230, L2750, L2780, , L2820, L2830, L4002
L1836	K0672, , L2750, L2780, L2810, L2820, L2830, L4002
L1843	K0672, L2275, L2390, L2425, L4230, L2750, L2780, L2810, L2820, L2830, L4002
L1845	K0672, L2275, L2390, , L2425, , L4230, L2750, L2780, L2785, L2810, L2820, L2830, L4002
L1847	K0672, L2390, L2425, L2430, L2750, L2780, L2810, L2820, L2830, L4002
L1848	K0762, L2390, L2425, L2430, L2750, L2780, L2810, L2820, L2830, L4002
L1850	K0672, L2750, L2780, L2810, L2820, L2830, L4002
Base code- custom devices:	Additional codes:
L1834	K0672, L2800, L2820, L2830, L4002
L1840	K0672, L2320, L2330, L2750, L2780, L2810, L2820, L2830, L4002
L1844	K0672, L2275, L2320, L2330, L2425, L2430, L2750, L2780, L2810, L2820, L2830, L4002
L1846	K0672, L2275, L2320, L2330, L2425, L2430, L2750, L2780, L2810, L2820, L2830, L4002
L1860	K0672, L2820, L2830, L4002

All additional codes that are not in the above table that describe components that cannot be physically incorporated into the device or which are incompatible with the base orthosis are also not covered.

Providers found to have billed for the noncovered codes are subject to recoupment.

## **Additional Information**

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It is a DVHA expectation that the providers will provide education to the beneficiary on the following:

- Care and use of the device; AND
- Appropriate skin/body part care related to the device use; AND
- Appropriate wear schedule; AND
- Customer support for any problem with the device, throughout the life of the device.

Documentation of this education must be kept in the provider record.

### **Prior Authorization:**

All generic “xx99” codes and non-specific codes require prior authorization.

Certain other codes also require prior authorization. Consult the fee schedule available on the Vermont Medicaid website at <http://dvha.vermont.gov/for-providers/health-services>

### **Special Information re: foot orthotics**

L3000: providers, note that devices billed with this code must demonstrate the intent of the UCB type orthosis, which is to provide a very high level of control for the rearfoot via high medial, lateral, and posterior walls made of rigid plastic. Providers must document the medical need for this significant level of rearfoot control and have the documentation available for legal and auditing purposes in their patient records. Note that there are other more specific codes for foot orthotics that do not require this degree of rearfoot control.

### **Contraindications/Precautions:**

Improperly fitted or inadequate devices may do more harm than good. It is vital that devices be appropriately assessed and reassessed, and properly constructed to provide the appropriate level of support and proper fit and function. It is Medicaid’s expectation that the provider who delivers the device to the patient is fully certified and that the provider has witnessed and documented that the device is properly fitted to the beneficiary, that the device provides the appropriate level of support, and that it is functioning properly. This documentation must be available in the beneficiary’s medical records for auditing purposes.

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